# CITY OF SCOTTSDALE 2004 COBRA/RETIREE BENEFITS ENROLLMENT FORM

| | | |
|---|---|---|
| ☐ New Enrollment<br>☐ Change in Enrollment<br>☐ Dependent Change<br>☐ Termination of Coverage | Qualifying Event Date _____<br>Qualifying Event _____ | Effective Date:_____ |
| **FOR HUMAN RESOURCES USE ONLY**<br>____ Original to Medical File _____ Copy to Payroll on:_____<br>____ Copies to Billing File | | Received on: |

| | | |
|---|---|---|
| Enrollee Last Name | First Name, MI | Social Security Number |
| Address | | |
| City | State | Zip |
| Date of Birth | Home Phone | Work or Cell Phone |

## MEDICAL

☐ **AETNA OPEN ACCESS EPO** (408)
☐ **MAYO HEALTH TRADITION PPO** (410)
☐ **AETNA OPEN CHOICE PPO** (418)

**LEVEL of COVERAGE**
Is this a coverage level change? ☐ Yes ☐ No
☐ Enrollee
AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

## DENTAL

☐ **FORTIS SUMMIT DENTAL (HMO)** (425)
Enrollee's Dental Facility ID# _____
☐ **CITY OF SCOTTSDALE SCOTTSMILES PPO DENTAL** (420)
☐ NO DENTAL

**LEVEL OF COVERAGE**
Is this a coverage level change? ☐ Yes ☐ No
☐ Enrollee
AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

## ALTERNATIVE MEDICINE

☐ ALTERNATIVE HEALTHCARE OPTIONS (431)
☐ NO ALTERNATIVE MEDICINE

**LEVEL OF COVERAGE**
Is this a coverage level change? ☐ Yes ☐ No
☐ Enrollee
AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

## ENHANCED VISION

☐ EYEMED VISION CARE (432)
☐ NO ENHANCED VISION

**LEVEL OF COVERAGE**
Is this a coverage level change? ☐ Yes ☐ No
☐ Enrollee
AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

**TWO SIDED FORM – BE SURE TO COMPLETE REVERSE SIDE**

# CITY OF SCOTTSDALE 2004 COBRA/RETIREE BENEFITS ENROLLMENT FORM

**DEPENDENTS (LIST ALL DEPENDENTS TO BE ENROLLED)**

| **Spouse Name** (Last, First MI) | Date of Birth | Gender |
|---|---|---|
| | | |

Spouse is covered on the following plan(s):
☐ Medical ☐ Dental, if Fortis give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision

| **Domestic Partner's Name*** (Last, First MI) | Date of Birth | Gender |
|---|---|---|
| | | |

Domestic Partner is covered on the following plan(s):
☐ Medical ☐ Dental, if Fortis give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision

| **Dependent 1 Name** (Last, First MI) | Date of Birth | Relationship<br>☐ Child<br>☐ Legal Dependent<br>☐ Dom Partner Child | Gender |
|---|---|---|---|
| | | | |

Dependent 1 is covered on the following plan(s):
☐ Medical ☐ Dental, if Fortis give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision

| **Dependent 2 Name** (Last, First MI) | Date of Birth | Relationship<br>☐ Child<br>☐ Legal Dependent<br>☐ Dom Partner Child | Gender |
|---|---|---|---|
| | | | |

Dependent 2 is covered on the following plan(s):
☐ Medical ☐ Dental, if Fortis give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision

| **Dependent 3 Name** (Last, First MI) | Date of Birth | Relationship<br>☐ Child<br>☐ Legal Dependent<br>☐ Dom Partner Child | Gender |
|---|---|---|---|
| | | | |

Dependent 3 is covered on the following plan(s):
☐ Medical ☐ Dental, if Fortis give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision

| **Dependent 4 Name** (Last, First MI) | Date of Birth | Relationship<br>☐ Child<br>☐ Legal Dependent<br>☐ Dom Partner Child | Gender |
|---|---|---|---|
| | | | |

Dependent 4 is covered on the following plan(s):
☐ Medical ☐ Dental, if Fortis give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision

Additional dependents may be listed on a separate page.

**AUTHORIZATION:** By execution of this enrollment form, I understand that I may not change the election during the coming year except in the event of a life change or during open enrollment. By my signature, I certify that the information on this form is true and correct, and that the listed dependents are my legal dependents.

Signature _____ Date _____

HR Signature_____ Date _____

***DOMESTIC PARTNERSHIP COVERAGE**

In addition to all other rules and conditions of city insurance coverage, the following apply to domestic partners coverage: In order for an enrollee to enroll a domestic partner for insurance coverage, both the enrollee and the domestic partner must complete the Domestic Partnership Affidavit. City of Scottsdale Human Resources must approve the affidavit prior to the commencement of coverage. Those with affidavits already on file do not have to resubmit. City enrollees who have domestic partnership insurance coverage are required to complete a Termination of Domestic Partnership form within 30 days of the termination of the domestic partnership. Children of a domestic partner may enroll for coverage only if the domestic partner is enrolled for coverage.

**QUALIFIED LIFE STATUS CHANGES**

You may not make changes to your benefit plans until the next open enrollment unless you experience a qualified life status change such as the birth of a child, marriage or divorce. If you experience a qualified life status change, you may add or cancel dependents but you may not change plans. You must notify HR within 30 days of a qualifying life status change. It is your responsibility to notify HR when a dependent (spouse/domestic partner or child) is no longer eligible for coverage. Failure to cancel an ineligible dependent from your coverage within 30 days will make you responsible for any claims incurred by an ineligible dependent.